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Andrew Golibersuch
agoliber@lesley.edu

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Integration Through Art: Using Art Therapy to Treat Spiritual Emergencies with Psychotic
Features

Capstone Thesis

Lesley University

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Andrew Golibersuch

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Thesis Instructor: Tamar Hadar, Ph.D.

Abstract

Spiritual emergencies are psychospiritual crises which often induce dramatic shifts in perception, emotional states, cognition, and social functioning. There is a significant lack of awareness of spiritual emergencies in the mental health profession, which contributes to mistreatment of individuals experiencing spiritual emergencies. Many symptoms appear similar to those of psychosis and are frequently misdiagnosed as such. Modern psychiatry aims to suppress and control symptoms of psychosis. This can be damaging to the recovery of someone experiencing a spiritual emergency. Spiritual emergencies are seen as a natural stage of development with immense positive potential for healing and growth. This literature review is an analysis of the concept of spiritual emergencies, including assessment, treatment and differentiation from psychosis. Art, which is a valuable resource for treating spiritual emergency, is a major focus of this thesis. While there is little published research into art therapy as a treatment for spiritual emergency, there is a growing evidence base for art therapy as a treatment for psychosis. This paper examines that evidence and reflects on how it applies to the treatment of spiritual emergencies. I will also share art I made during my own spiritual emergency and discuss how it enabled my recovery.

Key words: Spiritual emergency, art therapy, psychosis, spirituality, case study

Introduction

Spiritual experiences have had a significant role in the development of the psyche throughout history (Grof, 1985; Watts, 2005, 2009). Such iconic religious leaders as the Buddha, Jesus, or Moses each had profound spiritual experiences that shaped the trajectory of their religions, and the psyches of their followers, for centuries. Indigenous spiritual leaders, often called in the western world “shamans”, also use intense spiritual experiences to guide their local communities (Grof, 1985; Grof & Grof, 1986/2017; Lukoff, 2007). Many of these spiritual experiences involve hearing voices, seeing visions, intense surges of energy, or instances of clairvoyance. In the spiritual context, these are seen as important, healthy and transformative events, and signs from a power greater than the individual (Arnaud & Cormier, 2017; Grof & Grof, 1986/2017). However, in modern western society, such experiences are typically considered as symptoms of serious mental illness, often resulting in hospitalization, as well as suppressive and sometimes harmful treatments (Grof & Grof, 1986/2017; Lukoff, 2007).

Most often, spiritual experiences like the ones described above are interpreted as delusions or hallucinations, and as such, signs of psychosis (Grof & Grof, 1986/2017; Turner et al., 1995; Lukoff, 2007). However, there is a contingent of professionals who frame these experiences as transpersonal phenomena. Transpersonal phenomena do not always cause dysfunction, but when they do, they are deemed to be spiritual emergencies. This is not a common stance, as most professionals in the mental health field are unaware of the concept of spiritual emergency as a possible differential diagnosis for psychosis (Viggiano & Krippner, 2010). Typically, mental health practitioners diagnose and treat such individuals as if they are experiencing psychosis, which can cause additional harm and might result in chronic mental health problems (Arnaud & Cormier, 2017). Therefore, it is important that mental health

practitioners develop awareness and understanding of spiritual emergencies, so that they may effectively treat individuals who might qualify for such diagnosis.

The use of arts and other creative practices has been proposed as a key aspect of successfully treating spiritual emergencies (Arnaud & Cormier, 2017; Grof & Grof, 1986/2017). However, little research has been conducted to ascertain the efficacy of the arts in treating spiritual emergency. However, there is a growing amount of research into the effectiveness of art therapy as a treatment for psychosis (Cawford & Patterson 2007; Havenik et al., 2013; Lynch et al., 2019; Parkinson & Whiter, 2016; Richardson et al., 2007). Some documented positive outcomes of art therapy as a treatment of psychosis include: reduction of negative symptoms, shifts in perspective, understanding and attitude towards one's experience, optimistic expectations of recovery, and increased control over psychotic episodes. As I will show, there is significant overlap of symptoms between psychosis and spiritual emergency. The goal of this thesis is to examine the use of art therapy as a treatment for psychosis, and explain how that research applies to treatment of spiritual emergency.

First, I will give an overview of psychosis and the cultural challenges in assessing delusions and hallucinations. Next, I will define spiritual emergency and examine the history of its development and reception in the mental health institution. Then I will review the factors that can help differentiate spiritual emergency from psychosis, followed by discussion of the dangers of misdiagnosing spiritual emergency as psychosis. Afterwards, I will investigate proper assessment and treatment of spiritual emergency. Once a basic understanding of spiritual emergency has been reached, I will analyze relevant research on how art therapy has been used to treat psychosis, and will suggest how that research applies to the treatment of spiritual

emergency. Lastly, I will end with a brief personal case study of the art I created during my own spiritual emergency, and the functions it played in my recovery.

Literature Review

Psychosis: Definition and Central Features

According to the National Institute of Mental Health (2021), psychosis is a break from reality that distorts one's thoughts and perceptions. During a psychotic episode, an individual has difficulty discerning what is real or unreal. There are five key categories of symptoms for psychosis disorders in the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-V): delusions, hallucinations, disorganized thinking, grossly disorganized or abnormal motor behavior and negative symptoms. Delusions are fixed beliefs that remain unchanging even when shown conflicting evidence. Hallucinations are "perception-like experiences that occur without an external stimulus" (American Psychiatric Association, 2013, p. 87). Disorganized thinking is determined by observing the individual's speech. If an individual rapidly switches topics, makes frequent tangential connections, or speaks in an incomprehensible manner, their thought process may be deemed disorganized. Motor behavior may be considered abnormal if it is excessively childlike, unpredictably agitated, or catatonic. Finally, negative symptoms include diminished emotional expression, a total lack of motivation, diminished speech output, decreased ability to experience pleasure and lack of interest in social interactions (American Psychiatric Association, 2013).

Impaired reality testing is central to classifying psychosis disorders (Arciniegas, 2015). The presence of delusions and/or hallucinations are confirmations of such impairment. Extremely disorganized thought and speech can also be evidence of impairment of reality testing. In essence, the World Health Organization and American Psychiatric Association specifically

require the presence of hallucinations, delusions, and/or disorganized thinking in a psychosis diagnosis.

Cultural Concerns Regarding Delusions and Hallucinations

Complications arise when attempting to determine the presence of a delusion or hallucination. According to the DSM-V, discerning between a delusion and a strongly held idea can be challenging, and depends on the individual's degree of conviction when faced with contradictory evidence. The DSM-V clarifies that "delusions are deemed bizarre if they are clearly implausible and not understandable to same-culture peers and do not derive from ordinary experiences" (American Psychiatric Association, 2013, p. 87). Similarly, the DSM-V states that "hallucinations may be a normal part of religious experience in certain cultural contexts" (American Psychiatric Association, 2013, p. 88). Therefore, it can be challenging for a clinician to accurately diagnose individuals who are experiencing seemingly psychotic episodes whose content is based in foreign cultural and/or spiritual contexts. Events that are often classified as hallucinations and delusions have many overlaps with spiritual emergency, so it is understandable that psychosis and spiritual emergency may be confused with one another. Interpretation of such events is greatly dependent on the assessor's framework, which might be limited if a mental health practitioner does not consider a broad the range of cultural classifications.

Spirituality in the Mental Health Institution

Historically, spirituality has not been considered an essential element of the Western mental health institution (Prusak, 2016). Spiritual experiences were thought to have imprecise meaning, and therefore were mostly ignored in clinical and research practices. As noted in early versions of the DSM, religion and spirituality were treated as causes of pathology, while their

positive or adaptive roles were diminished or nullified. Additionally, those in the mental health field were far less likely to consider themselves religious or spiritual, so that they did not weigh the potential intersectionality of spiritual experiences and mental health. Therefore, it is unsurprising that for much of the history of western mental health, therapists were not trained to assess or address religious or spiritual issues (Turner et al., 1995; Prusak, 2016).

Ethically, clinicians are obligated to understand and consider appropriate treatment regarding a client's cultural, religious, and spiritual context (American Psychiatric Association, 2017). However, studies have found that clinicians frequently assess religious or spiritual concerns based on their personal experiences or their own culture's norms rather than those of the client (Prusak, 2016). This may result in an incomplete or incorrect diagnosis. Therefore, it is of the utmost importance for a clinician to evaluate and reflect on their attitudes towards religion and spirituality when interacting with a new client. With expanded self-awareness and continual training in cultural and spiritual competency, a clinician can avoid ideological countertransference and offer optimal services that value the client's beliefs and experiences (Prusak, 2016).

Nevertheless, there is some positive momentum regarding spirituality in the mental health institution in the last four decades (Turner et al., 1995; Prusak, 2016). After persuasive lobbying, Turner et al. (1995) were able to convince the committee that published the DSM-IV to include a new V-Code 26.89: "Religious or Spiritual Problem". It created an official non-pathological end of the spectrum for issues related to religious or spiritual concerns. While the inclusion of this new category was a step forward, the original draft had included more specific references to mystical and near-death experiences, which the American Psychiatric Association chose not to include. The authors of the V-Code relating to spirituality argue that the diagnostic category that

ended up in the DSM-IV does not include specific enough examples that would assist in diagnosis. Lukoff has since proposed that two additional diagnostic categories (mystical experiences with psychotic features, and psychotic episode with mystical features) also be added to the DSM, but they have not yet been considered for inclusion in the DSM.

The addition of V-Code 62.89 to the DSM has not received adequate attention in practice. Recent studies have found that the use of V-code 62.89 remains limited, even among those who are aware of its creation. In a survey of a group of 258 psychologists, only 44.7% were aware of the V-code (Prusak, 2016, p. 180). Of those who were aware of it, only 11.2% had used it in diagnosis in the last year; only 19.2% had ever used it, which equates to around 8% of the original 258 surveyed individuals. Another survey of 333 psychologists (Prusak, 2016) found that only 6.2% had used the Religious or Spiritual Problem V-code. Additional study is needed to determine to what degree the low rate of use is attributed to lack of awareness of clinicians versus the rate of occurrence of qualifying events.

Awareness of the code is only an initial step in it achieving appropriate levels of use. Another study of 100 psychologists (84% from private practice) showed that those surveyed found the diagnostic category helpful, 65% of whom said they would use the diagnosis more often if insurance companies considered it billable (Prusak, 2016, p. 181). In order for a clinician to be paid by insurance, any use of this V-code must be supplemental to a pathological diagnosis, which in some ways counters the purpose of using it. Therefore, it seems that proper use of this V-code requires a change in the system of insurance company reimbursement, in addition to increased awareness among clinicians.

The Religious and Spiritual problem V-code was inspired by the work of Stan and Christina Grof, which will be extensively explored in this thesis. The Grofs coined the term,

“Spiritual Emergency”, a prime example of a religious or spiritual problem, and a differential diagnosis for psychosis. While the term spiritual emergency can be officially diagnosed using V-code 62.89, there is a lack of awareness, education and understanding of the concept among mental health professionals (Viggiano & Krippner, 2010). In the next section, I delve deeper into this concept that lies at the heart of this thesis.

Spiritual Emergency

Definition of Spiritual Emergency

Spiritual Emergency is a category of psychospiritual conditions that encompass a variety of crises (Grof & Grof, 1986/2017, 1989). Common symptoms include dramatic shifts in perception, emotional states, cognition, and social functioning. In extreme cases, there is a distinct inability to perceive the world according to societal norms, and to communicate and behave within those norms. Such non-ordinary states of consciousness are often categorized as some form of psychosis by the modern medical model of psychiatry and are therefore seen as pathological (Lukoff, 2007). From the framework of a spiritual emergency, such states are a natural stage of development with the potential for immensely positive outcomes (Grof, 1985; Viggiano & Krippner, 2010). Outcomes include psychosomatic and emotional healing, personality growth and change, consciousness evolution, gaining a deeper understanding of oneself and one’s place in life, and creative problem solving of difficult situations (Assagioli, 1989; Grof & Grof, 1986/2017).

Development of Spiritual Emergency

Stan Grof’s work on non-ordinary states of consciousness began during his M.D. training at Charles University in Prague, where he studied the effects of non-ordinary states of consciousness induced by psycho-pharmaceutical substances (Cook, 1997). In the 1960’s he

began teaching psychiatry at John's Hopkins University and became chief of psychiatric research at the Maryland Psychiatric Research Center, where he studied the treatment of alcoholics and terminally ill cancer patients using substance-induced non-ordinary states of consciousness. Seeking a more organic yet controlled way of inducing non-ordinary states of consciousness, Stan and his wife Christina developed the holotropic breathwork method.¹ In the course of their research into non-ordinary states of consciousness, the Grofs encountered many phenomena that could not be easily relegated to the Western model of consciousness. Therefore, the Grofs began working on a new model, which eventually became known as Spiritual Emergence and Spiritual Emergency.

The Grofs' lineage can be traced back to the likes of William James, Roberto Assagioli and Carl Jung, who all considered the interplay between spirituality and psychology, in what would later be known as transpersonal phenomena (Viggiano & Krippner, 2010). Carl Jung's *The Red Book* is a prime example of a spiritual emergency processed through narrative and artistic exploration. A contemporary and collaborator of the Grofs and pioneer of modern psychology, Abraham Maslow, firmly believed that mystical experiences and mental illness were separate phenomena. Maslow emphasized that while the two may seem similar, they should not be confused, as mystical experiences are particularly conducive to self-actualization and self-realization (Grof & Grof, 1986/2017). In the 90's and 2000's, David Lukoff, one of the authors of the Religious and Spiritual Problem V-code, was the main champion of the spiritual emergency movement (Viggiano & Krippner, 2010).

¹ Holotropic breathwork is a method of controlled hyperventilation which deepens access to the unconscious. Trained facilitators lead participants through the deep breathwork which induces a non-ordinary state of consciousness. The participant is encouraged to fully express the content that emerges, and then reflect on the healing wisdom and insight gained from the experience (Cook, 1997).

Viggiano and Krippner (2010) conducted an inquiry as to whether the Spiritual Emergency framework has stood the test of time. The authors reviewed the spiritual emergency literature and interviewed the director of the Spiritual Emergence Network, an organization founded by the Grofs to help people experiencing spiritual emergencies find appropriate treatment. They concluded that the spiritual emergency framework was ahead of its time, and faced significant resistance from the predominant medical model of psychiatry. However, the framework has since taken hold among enthusiasts of humanistic and transpersonal psychology. The current push in the field of psychology to be more culturally sensitive and inclusive may open the path of the concept of spiritual emergency to gain wider acceptance and utilization. If such acceptance were to occur, those experiencing spiritual emergency would have a higher likelihood of receiving effective treatment. This would likely result in higher recovery rates, which may also influence insurance companies to adjust their reimbursement criteria, further increasing the likelihood of the spiritual emergency framework being utilized.

Triggers of Spiritual Emergency

Grof (1985) states that some spiritual emergencies are simply spontaneous in nature, but most are triggered by one or more significant events. Some factors are purely physical, for example, extreme bodily exertion, severe disease, injury caused by an accident, childbirth, miscarriage, and heart attack (Grof & Grof, 1986/2017). Intense emotional experiences such as the death of a close friend or relative or ending of a romantic partnership can also contribute to a spiritual emergency. Major life events such as being fired from a job, having a house burn down, or failing out of school also act as triggers for some people (Bronn & McIlwain, 2015; Grof & Grof, 1989). Intense spiritual practices such as vipassana meditation or kundalini yoga have also

been known to cause a spiritual emergency. Lastly, a common factor in spiritual emergencies is the use of psychedelic or entheogenic drugs (Grof, 1985).

Types of Spiritual Emergency

Based on the work of Stan and Christina Grof, Goretzki et al. (2009) identified 10 separate categories of spiritual emergencies. It is beyond the scope of this paper to explain each in detail, but a quick description is included here. The types of spiritual emergencies include (1) Dark Night of the Soul – a period of great suffering, confusion, loss, grief, and meaninglessness; (2) Awakening of Kundalini – an unblocking of the chakra energy system outlined by the Hindu, Buddhist and Taoist yoga traditions that often results in intense bodily sensations, pains and uncontrolled movement, and/or visions; (3) Shamanic Crisis – a loss of contact with consensus reality due to intensely fearful or euphoric states, visions and/or voices which content contains spiritual archetypes; (4) Episodes of Unitive Consciousness – peak experiences with a transcendental awareness of unity, frequently accompanied by intense wonder, awe and/or ecstasy; (5) Psychic Opening –out of body experiences, extrasensory perception, precognition, premonitions; (6) Past Life Experiences – an emergence of strong emotions and/or memories associated with a person from another time or place; (7) Near Death Experiences – an event of (seemingly) impending death that can evoke sensations of bodily detachment, total dissolution, extreme fear or total serenity and a profound shift in the way one experiences reality; (8) Possession States – an external force exerts control over the individual's body; (9) Activation of the Central Archetype/Psychological Renewal Through Return to the Center - one feels as if they are at the center of existence during a grand battle of forces (eg. good and evil), common themes include death and rebirth, martyrdom, a return to the beginnings of the world; (10) Experiences of Close Encounters with UFOs – reported abductions by aliens that result in serious emotion,

intellectual and spiritual distress (Bronn & McIlwain, 2015; Goretzki et al., 2009; Grof & Grof, 1986/2017; Viggiano & Krippner, 2010).

Differentiation from Psychosis

Many, if not all, of these experiences have no logical or socially acceptable place in modern Western norms and culture (Grof & Grof, 1986/2017). Additionally, accurate diagnosis can be challenging since many surface level symptoms of spiritual emergency appear to be similar to symptoms of other psychosis disorders (Arnaud & Cormier, 2017). It is therefore understandable that these experiences frequently get diagnosed as some form of psychosis disorder.

While differentiation between spiritual emergency and psychosis can be difficult, a number of factors assist in coming to a proper diagnosis. First, spiritual emergencies are often sudden, presenting as acute “psychotic like” states in people who have not shown signs of psychosis disorders in the past (Arnaud & Cormier, 2017). In contrast, psychosis disorders are frequently the result of adverse development over an extended period. Other circumstances that can push a diagnosis towards spiritual emergency include good pre-episode functioning, a positive attitude towards the experience, minimal risk of homicidal or suicidal behavior, and a stressful precipitating event (Lukoff, 2007). Additional factors that are more of a spectrum include the duration of the state, to what degree the individual can control entry into the state, and to what degree the individual’s habits deteriorate. None of these factors are silver bullets in determining a diagnosis, but they each contribute to differentiation.

As noted earlier, the presence of hallucinations and/or delusions frequently leads to a diagnosis of psychosis; however, this can be misleading. First, the content of delusion or hallucination is not sufficient to discern whether an individual is experiencing a spiritual

emergency or psychosis (Arnaud & Cormier, 2017). Additionally, the context in which the diagnostician evaluates the client may complicate proper identification. The DSM-V states that “ideas that may appear to be delusional in one culture (ex. Sorcery and witchcraft) may be commonly held in another” (American Psychiatric Association, 2013). Lukoff (2007) goes further by asserting that empirical studies of people who have been labeled as deluded and who are also religious call into question the criteria for assessing delusions. Particularly problematic is the criteria that if a belief is held with absolute conviction, but outside the social norms, it is often labeled delusional. However, most personally meaningful beliefs are held with absolute conviction; therefore that, in and of itself, should not cause a belief to be labeled delusional. According to Lukoff, delusions and their content should be assessed by how much they interfere with an individual’s life, and their emotional impact.

Dangers of Misdiagnosis

Leading experts in this area assert that misdiagnosis leading to pathologizing labels and symptom repression treatment can have a harmful impact on people experiencing spiritual emergencies (Grof & Grof, 1986/2017; Arnaud & Cormier, 2017; Lukoff, 2007). Suppressive treatments often disrupt the positive potential of a spiritual emergency. Not only does this prevent psychosomatic and emotional healing from taking place, it can also lead to further trauma. Someone who had the potential to move through a spiritual emergency in a matter of months, may become chronically dependent on pharmaceuticals and therapy. This can lead to deterioration of personality and long-term mental health challenges. Thus, effective treatment must be grounded in careful assessment of the underlying causes of psychotic episodes.

Assessment of Psychosis and Spiritual Emergency

The first priority in mainstream assessment of psychosis is identifying the cause of the psychotic symptoms. This includes obtaining a psychiatric, neurological and general medical history by interviewing the client and corroborating with family members and other collateral contacts (Arciniegas, 2015). Additionally, a thorough medical examination, medication review and drug screening should be performed. Clinicians are encouraged to use scales such as the Brief Psychiatric Rating Scale, Positive and Negative Syndrome Scale, Neuropsychiatric Inventory and Clinical-Rated Dimensions of Psychosis Symptom Severity scale when evaluating an individual for psychosis. However, according to Arnaud and Cormier (2017), the medical model focuses primarily on biological causes and does not adequately acknowledge the possibility of causes of psychological distress being rooted in the transaction process between the individual and their environment.

It is important to note that not all crises traditionally viewed as psychosis are spiritual emergencies, and not all spiritual emergencies would appear to be psychosis (Grof & Grof, 1986/2017). First, to be considered a spiritual emergency, there must be no underlying organic brain disorder or infection, or other physical disease that could cause non-ordinary states of consciousness. Additionally, there would need to be a transpersonal component; some aspect of the crisis must go beyond the individual's personal identity. Often this comes in the form of interaction with gods, angels, demons or other spiritual entities (Grof & Grof, 1989). Other common examples are states of mystical union, dissolution of the ego, sequences of metaphorical death and rebirth, out-of-body experiences, past life experiences, extrasensory perception, intense energetic phenomena (such as a Kundalini awakening) or patterns of unrelenting synchronicity.

Is Alternative Treatment Viable?

According to the Grofs (1986/2017), in some cases it may be quite difficult to determine whether one is undergoing an episode of spiritual emergency or psychosis. It may be necessary to make such a determination after alternative treatments are tested. However, the Grofs (1986/2017) also mention that even if someone is identified as having a spiritual emergency, there are several factors that are used to determine whether alternative treatments are viable. Firstly, the client must be in reasonably good physical health to ensure that they can endure the physical and emotional stress that often comes with direct treatment of spiritual emergencies. The client must also be able to perceive their condition as an internalized psychological process, and cooperatively engage with the treatment team. Therefore, if a client has extreme delusions, hallucinations, or histories of severe externalization, projection, or violence, which prevent cooperative engagement, they may not be able to establish the therapeutic relationship needed to approach treatment from a spiritual emergency perspective. Similarly, if a client has an extensive history of hospitalization, alternative treatments may be difficult to implement.

Treatment

The treatment of psychosis and spiritual emergencies have many similarities, as well as some key differences. Treatment in the areas of strengthening support systems, family involvement, community connection and social engagement are present in both treatment of psychosis and spiritual emergency (Arciniegas, 2015; Arnaud and Cormier, 2017). The primary treatment in the mainstream medical approach is the use of antipsychotic medication to control symptoms (Arciniegas, 2015). Unfortunately, antipsychotics often have significant negative side effects for people experiencing spiritual emergency and can impede the capacity of an individual to do the work needed to fully process the experience (Arnaud & Cormier, 2017; Grof & Grof,

1986/2017; Lukoff, 1998, 2007; Wood, 2020). Therefore, they must be used with immense intentionality when deemed necessary to enable the therapeutic work.

While mainstream treatment of psychosis focuses on suppression of symptoms, the spiritual emergency model concentrates on fully engaging with the experience in order to illuminate insights for healing and growth (Grof & Grof, 1986/2017; Viggiano and Krippner, 2010). Spiritual emergencies are not seen as mental illnesses that need to be cured. They are viewed as transformative events that deepen the understanding of one's psyche, enable a realignment of the personality around new values, and illuminate new perspectives and creative solutions to life's problems (Assiagli, 1989; Grof, 1985, Grof & Grof, 1986/2017, 1989).

Stabilization. In his book *Beyond the Brain*, Grof (1985) discusses how an ideal course of treatment of Spiritual Emergency would create a supportive enough framework that the client could be encouraged to enter and move through the spiritual emergency fully. However, fully experiencing a spiritual emergency is not helpful if the client is dysfunctional or disconnected from consensus reality. Therefore, it may be necessary for a client to avoid any stressful or overstimulating situations, as well as to temporarily discontinue spiritual practices. According to Arnaud and Cormier (2017), the ideal location for such treatment would be in a retreat setting, a friend or family member's home, or in extreme cases, a hospital.

If a client is having a difficult time functioning, Arnaud and Cormier (2017) describe how activities such as gardening, exercise, and working with one's hands are useful for grounding the client. Changing the client's diet to include "grounding" or "heavy" foods may also be helpful. Such foods include whole grains, beans, dairy products, and meat, with the removal of sugar, caffeine and other stimulants (Lukoff, 2007). In extreme cases, Grof acknowledges that it occasionally may be necessary to temporarily administer minor

tranquilizers. Often, containment and tempering of the experience is needed so that the client can slowly and effectively process and integrate the spiritual emergency (Arnaud & Cormier, 2017). Once the client is stabilized, regular experiential sessions may reduce interference into everyday life caused by the spiritual emergency (Grof & Grof, 1986/2017). Some of the experiential practices Grof recommends trying, include Gestalt, psychosynthesis, Jungian active imagination, Mandala drawing, focused body work, expressive movement, creative writing, the use of music and the arts, and holotropic breathwork. Once a course of treatment has been established, individual therapy, sometimes more than once per week, is a vital tool towards recovery (Arnaud & Cormier, 2017).

Treatment Steps. To effectively treat a Spiritual Emergency, a clinician must first establish a strong, trusting relationship with the client (Grof, 1985). Having trust in a caring, non-judgmental clinician is vital in staying grounded, as Spiritual emergencies can be disorienting and even terrifying. A negative reaction from a professional can exacerbate feelings of isolation associated with the difficult emotions and often terrifying nature of a spiritual emergency (Turner et al., 1995). Two of the most important factors for recovery are feeling support and acceptance free of negative judgements. Leveraging a strong therapeutic relationship, a therapist can help the client reach a new understanding of their experience. A therapist should help the client reduce the fear that they are “going crazy” and conceptualize their experience in a non-pathological psychospiritual framework (Arnaud & Cormier, 2017). If the therapist can approach the experience with respect and a positive attitude towards the healing and transformative nature of a spiritual emergency, the client will be more likely to be able to utilize the positive potential of the experience (Grof, 1985). The end goal of SE treatment is for the client to integrate their spiritual experience into everyday life and develop a life affirming

personal belief system that allows them to learn and grow while also being a functioning member of society (Lukoff, 2007).

To successfully navigate a spiritual emergency, both the therapist and client must cooperate with and support the process, rather than try to fight against it (Grof & Grof, 1986/2017). If the client recognizes the intrapsychic nature of their spiritual emergency, they will be able to do the work needed to progress through it, heal, and ultimately grow as a person. A therapist must normalize the experience by giving the client additional information and a positive context (Lukoff, 2007). Combined with assurance that the condition is temporary, the therapist can help a client develop a positive attitude towards the process (Assagioli, 1989).

Once the client has developed a cooperative attitude towards the therapeutic work, the therapist can begin helping the client foster the willpower to “control and master the drives emerging from the unconscious, without repressing them through fear and condemnation” (Assagioli, 1989, p. 47). During therapy, a client should learn to recognize and assimilate the energy arising from the spiritual emergency. Additionally, the client will need to learn to transmute or sublimate any aggressive or otherwise troublesome energies and drives they might experience. Ideally, the therapist would help the client learn to use the energy surfacing during a spiritual emergency for “altruistic love and service” (p. 47).

In therapy sessions the client would work through the transpersonal materials that are emerging through the experience, as well as in dreams, often by using artistic materials (Arnaud & Cormier, 2017). One important aspect of that process is to help the client differentiate between everyday reality and transpersonal phenomena such as Jungian archetypes (Grof & Grof, 1986/2017). For many, this involves learning to differentiate the “body ego” from the “Self” that

is experiencing the archetypal process.² To do so, a skilled therapist would help the client probe for personal meaning within their symptoms, while also helping them to see the universal dimensions of their experience (Lukoff, 2007).

Once the client strengthens their ability to address emerging material in therapy sessions, it is important to help the client design routines or rituals that will allow them to confront that material in their everyday life (Grof & Grof, 1986/2017). Examples include meditation, “introspective experiencing facilitated by music”, or other reflective practices. Having scheduled times for these reflective practices will help to prevent any intrusions from the unconscious elements of the spiritual emergency.

Treatment Goals. By working through these steps, Assiagoli (1989) argues, the therapist will help the client move through “various phases of reconstruction of his personality around a higher inner-center” (p. 47). In other words, the client’s personality will evolve to align around moral values, altruism, love, and the interconnected nature of existence. Individuals who succeed in integrating the inner journey of a spiritual emergency “become intimately familiar with the territories of the psyche” (Grof, 1985, p. 299). This comes with new perspectives and creative solutions to life challenges, an increased sense of purpose and direction, and an overall improved sense of wellbeing (Grof, 1989).

The Grofs (1986/2017), Lukoff (2007), Arnauad and Cormier (2017) and others mention the usefulness of art and creativity in the treatment of spiritual emergencies. Unfortunately, there appears to be little research on how art therapy has been used to support individuals experiencing

² The “body ego” is the individualized self that experiences everyday life, and “the Self” (as opposed to “the self”) is the transpersonal element that we all have in common. Examples of names from different spiritual traditions that are examples of the Self include the Godhead (Christianity), the Tao (Taoism), and Brahman (Hinduism) (Watts, 2005, 2009).

spiritual emergencies. However, there is a considerable amount of research on the use of art therapy in treatment of psychosis disorders. This study will focus on the different ways art therapy can support individuals experiencing a spiritual emergency. Given that there is much overlap in the symptoms between psychosis and spiritual emergency, in the next section I will review a selection of studies focused on art therapy and psychosis, and suggest how their results apply to the treatment of spiritual emergencies.

Using Art Therapy to Treat Spiritual Emergency and Psychosis

Art Therapy: Definition

The American Art Therapy Association (AATA) defines art therapy as an integrative mental health service that utilizes active art-making, the creative process, and applied psychological theory within a psychotherapeutic relationship to support clients' treatment goals (AATA, 2017). The art media, the process of art making, and the resulting art are all used in the therapeutic process (Art Therapy Credentials Board [ATCB], 2021). Making art in a therapeutic setting provides "alternative modes of receptive and expressive communication, which can circumvent the limitations of language" (AATA, 2017, p. 1). Art therapy can be utilized to address personal, relational, or communal concerns including: exploring feelings, reconciling emotional conflicts, cultivating emotional resilience, improving cognitive and sensory-motor functions, fostering self-esteem and self-awareness, managing behavior, promoting insight, improving reality orientation, promoting relaxation and grounding, reducing anxiety, enhancing social skills, reducing and resolving conflicts and distress, and advancing societal and ecological change (AATA, 2017; ATCB, 2021; Ursuliak et al., 2019).

There are a wide variety of complex interventions and psychotherapeutic techniques used in art therapy which promote creative expression for the purposes of therapeutic healing (Wood,

2013). Wood (2013) states that a primary element of art therapy is the facilitation of self-expression using art materials. Another key component is the use of aesthetic form to create meaning for and contain the user's experience. The artistic process also is helpful in enabling the client to engage in dialogue and induce insights about their experience, relate to and experience themselves in a new way, and expand their means of relating to other people (Ursuliak et al., 2019; Wood, 2013). Art therapy can also help a client who identifies primarily as sick or damaged to broaden their identity, as well as increase hope and confidence in recovery (Ursuliak et al., 2019).

Art Therapy in Treatment of Psychosis

The National Institute of Clinical Excellence (NICE) in the United Kingdom recommends that art therapy be considered for treatment for both acute episodes and long-term recovery from psychosis or schizophrenia (NICE, 2014). The reasoning behind this recommendation is chiefly that expressive therapy has been shown to reduce negative symptoms, both in the short term and after an extended period of time. Additionally, the report recommends that art therapy as treatment for psychosis can be used to: (1) enable people to experience themselves and relate to others in new ways, (2) make sense of their experience and express themselves more fully through aesthetic forms, and (3) expose emotions through the creative process allowing clients to learn to accept and understand those feelings as well as ascertain from where those feelings originate. All of this is done in a way that is paced to the needs of the client. The report also mentions that the six studies that were included in making these recommendations were focused on group work. Therefore, the report recommends that art therapy be done in groups, and also stresses the need for additional research on the effects of individual art therapy. While the NICE report does not mention spirituality specifically, the

recommendations they provide can also be directly applied to those experiencing spiritual emergencies. The report included studies from all different expressive modalities, but two of them were specific to art therapy (Green et al., 1987; Richardson et al., 2007).

In 2007, Richardson et al. conducted a randomized control trial to see if art therapy is effective as an adjunctive treatment for schizophrenia. After an extensive recruitment phase, 90 participants, about 20% of the original cohort, were assigned to two treatment groups; 47 participants were given standard treatment, and 43 were given art therapy in addition to the standard treatment. The baselines for the many measurements conducted by the researchers were statistically insignificant. While most of the scales showed no statistical difference between the two groups' post treatment, there was a significant benefit on the Scale for the Assessment of Negative Symptoms (SANS) for the group receiving art therapy treatment. Additionally, the control group was found to have deteriorated during post-treatment 6-month follow up, while the art therapy group showed slight improvement. However, it is worth noting that this trial was underpowered both in number of participants and length of treatment.

Richardson et al. (2007) showed that art therapy is beneficial to the client-therapist relationship. According to the authors, art therapy can locate and defuse problematic feelings that a client experiencing psychosis symptoms feels towards a therapist. Since a trusting relationship with a therapist is the most important element in treating spiritual emergencies, the ability to address problematic feelings towards a therapist is vital for success.

Additionally, these researchers found that art therapy allows clients to feel conflicting or challenging feelings as non-threatening and provides a way to contain fears associated with psychosis. They found that such containment leads to increased engagement and reduction in the likelihood of early termination from services. As discussed earlier, spiritual emergencies are

often terrifying experiences that trigger significant discomfort and difficult emotions. Containing those fears and allowing the difficult motions to release in a safe way is an important step in treating spiritual emergencies and therefore art therapy could prove as highly valuable in such cases.

The largest quantitative study on the effectiveness of art therapy with people with schizophrenia, the Matisse RCT was also not completed in time to be included in the NICE (2014) report. The researchers (Crawford et al., 2012), however, did not find any significant difference between art therapy and standard care in addressing hallucinations and delusions or in reducing negative symptoms. However, in a comprehensive review of the Matisse RCT, Wood (2013) highlighted a number of weaknesses that call the Matisse study results into question. First is that the art therapy process was not adapted for use with people with a diagnosis of schizophrenia. Many of the leaders did not believe the group approach was suitable for people with a diagnosis of psychosis. Additionally, the art therapy model was not standardized which created confusion for many of the group leaders. This caused a lack of consistency in the art therapy approach at different trial sites. Also, the clients were not adequately prepared to engage in art therapy. There was also a low attendance rate in the art therapy trial groups. Group membership consistency was questionable raising doubts about the viability of the group therapy process due to lack of group cohesion. Additionally, whether the clients desired to be part of the trial seems not to have been considered. Also, the mental health history of each participant varied significantly. Lastly, while much of the artwork was collected during the trial, it was not considered in the data analysis therefore the trial lost a valuable component of the data. While large-scale randomized control trials are important for providing conclusive evidence and

securing funding supporting the use of art therapy to treat psychosis, future studies must be designed in ways that more effectively measure the effects of art therapy.

Results from large quantitative studies are conflicting as to the benefits of art therapy as a treatment for psychosis, and mainly focus on the reduction of negative symptoms. On the other hand, qualitative research, focusing on participants' experiences and self-reported benefits of art therapy frequently shows positive results. Several authors have examined the benefits of art therapy for treating psychosis deploying qualitative methods (Lynch et al., 2019; Parkinson & Whiter, 2016; Havenik et al., 2013; Teglbjaerg, 2011; Ursuliak et al., 2019). Lynch et al., (2019) postulate that many of the benefits of art therapy may not be effectively measured by focusing mainly on symptom reduction. This may be why a majority of the research studying the benefits of art therapy is qualitative.

In a 2019 qualitative study, Lynch et al. explored how a group of eight individuals, who had been recently diagnosed with psychosis, experienced art therapy. The authors hoped to determine whether the individuals found art therapy helpful, what specifically about art therapy was helpful, and what were the mechanisms for change in the art therapy practice. The authors were particularly interested in researching these questions regarding people who were early in their treatment. Up until this study, much of the research had been done with individuals who had been diagnosed with a psychotic disorder for a significant period of time. With inappropriate treatment being so detrimental to recovery from spiritual emergencies, examining the early treatment period from this study can shed critical information on how to commence a successful treatment trajectory.

All participants underwent group art therapy together, and half also engaged in individual art therapy. After completing treatment, the researchers conducted semi-structured

interviews, which explored each individual's experience with art therapy using open and non-leading questions. This study had a small sample size, and the authors pointed out that difficulties with recruitment may illuminate a deficiency in the availability of art therapy to those with first episode psychosis.

There were several factors that the clients found helpful about the art therapy process (Lynch et al., 2019). Clients mentioned that the unpressured environment created a relaxed and calm atmosphere. The clients also described the experience as pleasurable and engaging. Such environments may also prove instrumental in helping individuals experiencing spiritual emergencies to develop a positive attitude towards their experience: an important step in successfully treating spiritual emergencies.

Another aspect highlighted by the authors (Lynch et al., 2019) relates to a sense of experimentation and exploration during art therapy, which enabled the clients to obtain a deeper understanding of themselves and stronger self-expression. While this study does not examine spiritual emergency specifically, it is connected because, as discussed earlier, strengthening one's understanding of the self is a main goal of treating spiritual emergencies. With that understanding comes the ability to differentiate oneself from the spiritual emergency. By utilizing strong self-expression, a client can share the themes that emerge from the transpersonal phenomena of their spiritual emergency, and more effectively find meaning in their experience.

The group art therapy process was particularly helpful in learning how to be with and relate to others, which contributed to clearer communication between the group members and leaders (Lynch et al., 2019). The authors found that art making provided a feeling of freedom in being and expressing oneself fully. The authors concluded that the group art making process also encouraged participants to see and explore the perspectives of others and to experience those

perspectives positively. The participants also mentioned having benefited from finding commonalities between the group members regarding their experience of psychosis, during the art making process. Additionally, absorption in the art provided a calming distraction and escape and was reported to be used as a coping mechanism outside of therapy.

As discussed earlier, feelings of isolation and terror are common in people experiencing a spiritual emergency. Using art therapy to cope with those difficult emotions provides a way for the client to stabilize. Additionally, having a space to connect with and relate to others, and learning how to effectively communicate allows the client to begin opening up about vulnerable topics associated with spiritual emergency. Making art relieves the pressure to find the right words and gives clients freedom to communicate in new ways. Once the client has made art about the spiritual emergency, it often becomes easier to find the words needed to discuss their challenges.

Clients also reported that the art therapy process led to an increased interest in art making, as well as contributed to their overall recovery (Lynch et al., 2019). According to the authors “art therapy appeared to encourage participants to explore their understanding of and reflect on their experiences, and for some, for this to change” (Lynch et al., 2019, p. 6). Additionally, the client's perception of themselves evolved when they began seeing themselves as skilled individuals with abilities and something to offer others rather than being solely identified as someone with mental health problems. However, the authors did not find that previously unconscious material was made conscious during the art therapy process.

Exploring one's experiences and perceptions and learning to change those perceptions is necessary for successfully recovering from a spiritual emergency. Someone experiencing a spiritual emergency may have a particularly negative or critical opinion of themselves or their

experience, so the finding that art therapy allows for some clients to reflect and change those thoughts is significant. Art therapy can play an important role in helping a client develop a positive attitude towards their experience, which as discussed earlier, is one of the most important steps in spiritual emergency treatment. However, this study did not find that previously unconscious material was brought to the surface. It may be the case that individual art therapy sessions would be more effective in examining unconscious material. Therefore, it would be prudent for additional research to be conducted on the effects of individual art therapy to treat spiritual emergency and psychosis.

Expanding on the theme of initial treatment of psychosis, Parkinson and Whiter (2016) conducted a study examining art therapy groups as an early intervention (EI) for psychosis. They intended to develop a group art therapy process for EI treatment, and to uncover how art therapy could be best used to fulfill clients' needs of expression, communication, social connection and self-awareness as well as to evaluate any improvements in clients' mental health.

The sessions were initially 90 minutes in length, once per week. However, clients requested longer sessions, so the authors increased session length to two hours. Each session began with a short warm up exercise. After the warm up, there was a longer period of unstructured art making, followed by additional group discussion, which allowed time for reflection.

Many of Parkinson and Whiter's (2016) findings of the effectiveness of art therapy in the treatment of psychosis complies with the finding of additional researchers (Lynch et al., 2019; Havenik et al., 2013), particularly in the areas of increased sense of achievement and confidence, a shift in one's perspective of self, management of difficult feelings, strengthening of self-expression, and the ability to share what may feel unspeakable. Parkinson and Whiter (2016) also

showed that art therapy helped clients develop optimistic expectations for recovery, which is an essential element of spiritual emergency treatment. According to the authors, art therapy also provided a structure that enabled clients to sort out their issues and address them one at a time, something that helped to ease the overwhelming nature of spiritual emergencies. Participants of this study reported to be able to assert a new identity, which is one of the desired outcomes of recovering from a spiritual emergency.

Another important element in recovering from spiritual emergency is seeking to understand one's experience of spiritual emergency. Havenik et al.'s (2013) multiple case study is of great valence in this respect. The authors explored whether art therapy would help clients to better understand their experiences of psychosis, and whether such understanding would help those clients better cope with their psychotic experiences. The five participants, aged 31 to 58, carried diagnoses of various forms of psychosis including bipolar disorder, schizoaffective disorder, schizophrenia and paranoid psychosis. Each participant suffered catastrophic effects from their experience of psychosis.

The authors specified three main findings (Havenik et al., 2013). The first is that group members were able to create a supportive, interactive and safe environment, with the art making process contributing to the sense of safety. The second is that the artistic work seemed to strengthen group interactions. Thirdly, spiritual and existential issues were found to be a main focus for many of the group members even though that was not an intention of the researchers. The authors also found evidence in the client reports for art therapy's ability to improve clients' sense of self and social awareness, and to reduce their negative symptoms. However, the authors recognize that it is unclear whether these improvements could be directly attributable to art therapy, the group process, exploration of the psychosis or a combination of all variables.

An important finding the authors raise relates to how the art therapy environment made clients feel comfortable enough to share challenging experiences, with some participants in the study sharing about such experience for the first time. People seeking treatment for a spiritual emergency may feel hesitant about sharing on topics that are not typically accepted in western culture, so this comfort level is vital for success. Another important finding was that the clients in this study reported that art therapy gave them tools to better understand their triggers of psychosis. This also applies to spiritual emergency, as a client must be able to prevent additional episodes that lead to dysfunction while processing the transpersonal content of their experiences.

Some participants of this study described how the experience of the art therapy process helped them to reconnect with themselves and find freedom from a frozen state of mind. The participants reported they were more capable of connecting to their inner self in constructive ways and felt more alive. This study provides evidence for art therapy as a tool to reconnect with one's self and life, which can be used in the context of treating spiritual emergency. Such a tool is particularly helpful for people experiencing spiritual emergency who are disconnected from themselves and their reality, or feel like they are "going crazy."

Participants reported that they were able to use art therapy to cognitively reinterpret their psychotic experience. Havenik et al. (2013) assert that exploring psychotic symptoms using the arts allowed the clients to distinguish the psychosis from the self, which is what enabled them to reinterpret their experience. The clients reported having clearer understanding of their symptoms as well as an improved ability to cope with those symptoms. The exploratory art deemed successful in this study can be applied to spiritual emergency because having a deeper understanding of one's experience is the core of the work with spiritual emergency. If a client can separate themselves from their spiritual emergency and reframe their experience, they will be

more likely to have a positive attitude, and a better chance of integrating the spiritual emergency experience into a functional lifestyle.

The most important finding of this study for this thesis is that spiritual discussions arose naturally, without instigation from the group leaders. At various points during treatment there were discussions of whether their unusual visual or auditory experiences were supernatural abilities, spiritual experiences, or symptoms of psychosis. Given that art therapy induced discussion of spiritual topics without direction from the group leaders, it is logical to assume that art therapy would stimulate similar conversations between people experiencing spiritual emergencies. With intentional design targeted towards examining spiritual topics, art therapy may prove to be well positioned to proficiently process transpersonal material.

Discussion and Case Study

It is clear that there is an emerging evidence base to show that art therapy is an effective treatment for people with psychosis disorders (Crawford & Patterson, 2007). While I was not able to find research regarding spiritual emergencies and art therapy specifically, due to the many similarities between psychosis and spiritual emergencies, the results from these studies also provide the foundation of evidence for using art therapy to treat spiritual emergencies. In order to strengthen justification for implementing arts-based treatments for spiritual emergencies, significant qualitative and quantitative studies must be conducted for all treatment methods of spiritual emergency, including art therapy.

A particular area lacking substantial research is the effectiveness of individual art therapy sessions in treating spiritual emergency or psychosis. What follows is a comprehensive review of how art was used in my own journey during and after a spiritual emergency. While the

therapist I was seeing at the time was not an art therapist, we discussed my art in sessions. Examples of the art from this time in my life are included in the appendices.

My spiritual emergency was an event of complete disintegration. Through this disintegration, I came to making art as a therapeutic and healing form of stabilization. Using the stability of my art as a foundation, I began to work to integrate my experience. To do so, I needed to gain a better understanding of my experience. Next, I sought to find my voice through art. Then I set out to communicate what was happening to me and what I was learning from my experience. Finally, I used art to self-actualize and fully integrate what came through the spiritual emergency into my everyday life. Each stage formed a strong foundation for the next phase. While there was a sequential element to this transformative art process, it was more cyclical than linear, with each subsequent stage both building on and continuing the work of each of the previous stages.

The initial steps of my spiritual emergency were intense and destabilizing. Art provided me an important tool for grounding and centering myself. Making art was an outlet that allowed my body to focus on an activity while it processed the intense emotions associated with my spiritual emergency. When my mind was racing, trying to make sense of an incredibly confusing series of events, and unable to contemplate complex creativity, I would give myself a basic set of directions. I would then follow those rules to completion, and pieces like the geometric art seen in Appendix A would emerge. After an extended period of art making, my thoughts would calm down and I would be more able to go about my day. Additionally, during times of perceived chaos, these art pieces served as reminders of structure and order.

Whenever I tried to explain what was happening to me using words, I would be met with confusing looks at best, and hospitalization at worst. This was because my understanding of

what was happening was distorted, and I could not find effective words to communicate. Making things worse was the fact that most of the professionals with whom I interacted did not attempt to help me better understand or express my experience. To this day finding the right words can be difficult, but I feel able to convey the ineffable qualities of my experience with art.

Overwhelmed by confusion, I attempted to achieve understanding through artmaking. During the planning process for an art piece, I would contemplate what meaning there might be in my strange experiences. Patterns, such as the ones seen in Appendix B, would emerge, that I then put on paper. While many themes arose, there were a few that became predominant. The first theme was that this was an experience meant to induce growth and healing, an important theme to explore in any spiritual emergency. Second was that I needed to find a balance of light and dark in my psyche, rather than be stuck in a constant battle. Third was the importance of and learning to be one with nature and the Tao.³ My art was a mirror in which I could reflect on my experience to understand what was happening to me.

Making art created distance so that I could separate from the experience and learn to differentiate my individual perspective from the transpersonal phenomena of the Self. In doing so, I was able to parse which elements of the experience were unique to me, and which had a universal quality. This is a vital step on the path of recovery from spiritual emergency.

Additionally, art provided a way to communicate with others, as well as myself. However, before this experience I had not made art since elementary school, so I did not know how to use it to communicate effectively. Therefore, I had to find my artistic voice before I could communicate specific ideas. To do so, I depicted exactly how I saw the world when I was in the midst of a spiritual emergency. What came from that process is the style of drawings seen in

³ The Tao is a key concept from Taoism meaning the way or path of the universe and natural condition of life (Watts, 2005, 2009)

Appendix C. Once I was confident that I had found my creative voice, I began drawing metaphorical representations of what happened to me during an episode, as well as the insights I had gained in reflection, as seen in Appendix D.

The themes that emerged in my art during each of these stages became the foundation of an ongoing cycle of psychological restoration. Many of my schemas for understanding reality broke down during my spiritual emergency and needed to be rebuilt. As I started to recover, making art felt like I was willfully constructing my personality, reconstituting an ego which had fully disintegrated. At the core of this reconstruction was a sense of love, service and connection with everyone and everything. Some examples of my process of actualization can be seen in Appendix E. As my recovery continues, art has served as a way to examine aspects of my ego, deconstruct personal defects, forgive myself, and reinforce personal strengths. This process can be incredibly useful, not just for those experiencing a spiritual emergency, but for anyone.

Conclusion

Overall, my spiritual emergency has had an immensely positive impact on my life. However, during the experience, that outcome seemed like a long shot. The treatment I received from the mental health institution may have prevented a complete catastrophe, but it also induced significant trauma, from which my art helped me to recover. In my decision to become an art therapist, I wanted to help prevent such trauma from occurring to others and increase their likelihood of successful recovery. I hope that this thesis is one step in spreading knowledge that will help people experiencing spiritual emergencies receive the treatment they need and deserve.

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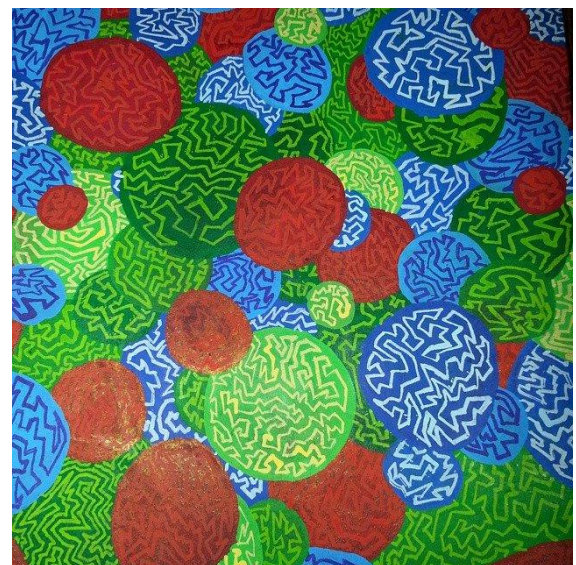
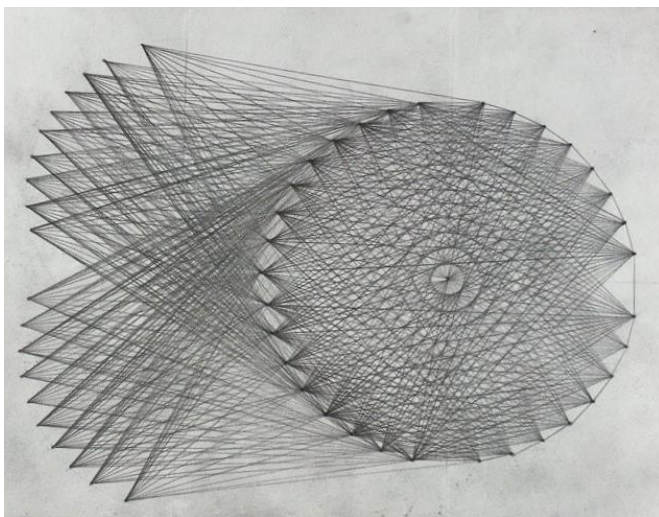
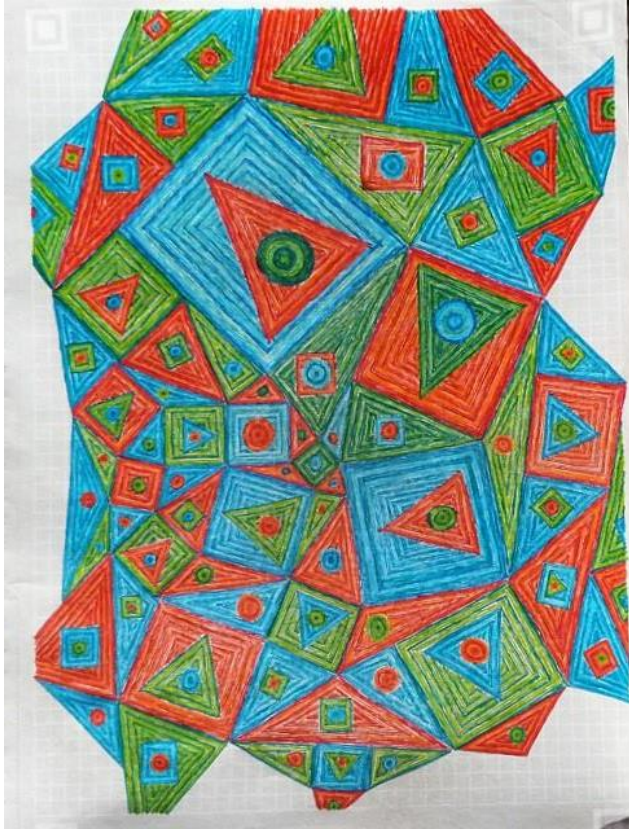
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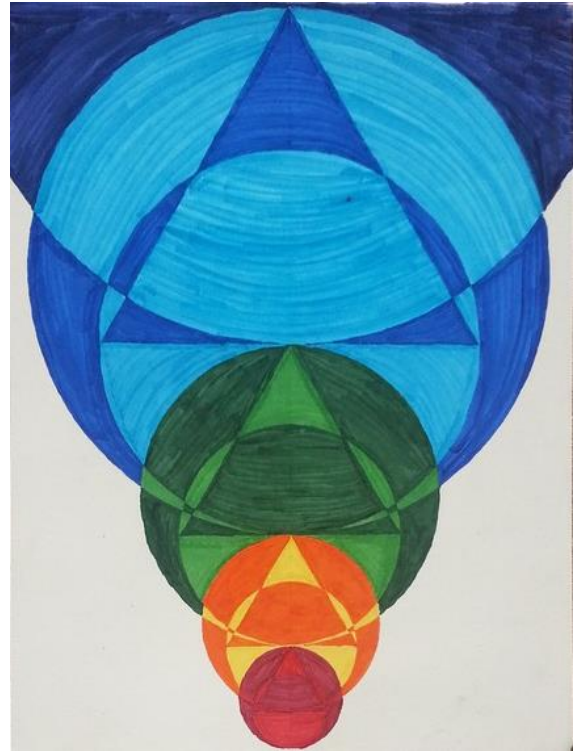
Appendix A

Stage 1: Stabilization



Appendix B

Stage 2: Understanding



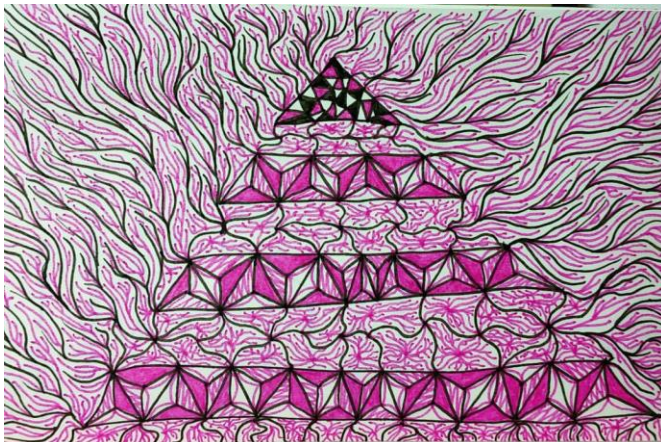
Appendix C

Stage 3: Finding Voice



Appendix D

Stage 4: Communication

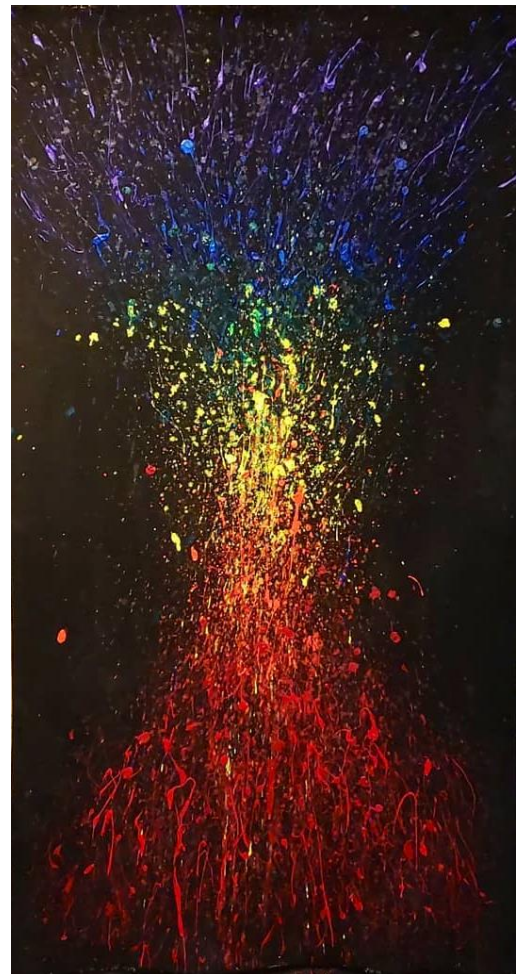


Stage 4: Communication (continued)



Appendix E

Stage 5: Actualization



THESIS APPROVAL FORM

**Lesley University
Graduate School of Arts & Social Sciences
Expressive Therapies Division
Master of Arts in Clinical Mental Health Counseling: Art Therapy, MA**

Student's Name: Andrew Golibersuch

Type of Project: Thesis

Title: Integration Through Art: Using Art Therapy to Treat Spiritual Emergencies with Psychotic Features

Date of Graduation: 5/5/2021

In the judgment of the following signatory this thesis meets the academic standards that have been established for the above degree.

Thesis Advisor: Dr Tamar Hadar, MT-BC